are reported, in which a greater or less amount of relief followed the operation. In the discussion which ensued there was a disposition to question the propriety of attacking the ganglion, yet that any measure was justifiable in these terrible cases seemed to be the conclusion of those present. The President somewhat oracularly finished the debate with "If the operation has done good, it is well; if it has not done good, it is not well." Which opinion is easily arrived at in retrospect, but does not aid very much in arriving at a decision whether to operate or not, in a given case.

Dr. J. H. **Barton**, of Philadelphia, exhibited a *wire splint to make extension in cases of synovitis of the wrist-joint*, which is ingenious and constructed upon principles easily applied to other joints.

The last article which it remains for us to notice is one upon *Strictures of the Œsophagus*, by Dr. H. F. **Campbell**, of Augusta, Georgia. It is based upon a number of observed cases which were more or less successfully treated by means of dilatation. To pass the stricture Dr. Campbell was obliged to resort to instruments of less size than the smallest œsophageal bougies, but by patience, perseverance, and delicacy of manipulation, he was in every case successful. Owing, however, to the care and attention required for a long period by these cases, the ultimate result is not always as good as in the first series of cases reported by Dr. Campbell. But Dr. Campbell's experience is most encouraging, showing that the milder method, when combined with rectal alimentation, offers equal, if not better prospects than any cutting operation. A considerable part of the paper is taken up with remarks upon the increasing number of these cases, produced by drinking condensed lye. The evil is a great one, and Dr. Campbell is quite right in insisting that some distinguishing marks should be placed upon packages of material which is so freely exposed to the children of a family, and which produced so many distressing and fatal results. Dr. Campbell is enthusiastic upon this topic, but his observation and the treatment of the cases he reports mark him as a first class surgeon, and his communication is an excellent one.

We have now completed the task set before us, and have taken notice of every paper contained in this large and handsome volume. It remains for us only to congratulate the Association upon the number of the papers presented to it, and to express the hope that its future volumes may be as good as this, its first one. It is but right for us to add, that the laborious work of editing the volume has been most admirably done by the Society's Recorder, Dr. Mears. S. A.

Art. XIX.—*Transactions of the American Gynecological Society.* Vol. VII. for the year 1882. 8vo. pp. 485. Philadelphia: Henry C. Lea's Son & Co., 1883.

Owing to a delay in publishing the *Transactions* of 1882, and an unusually early presentation of those of 1883, we have the volumes of the two years on our table at the same time, but we shall be obliged for want of space to postpone the review of the volume for 1883. The two annual meetings were held in Boston and Philadelphia respectively, the latter having the larger attendance, and the former presenting much the larger volume, this being due to the greater length of the papers in 1882; the number, fourteen, having been the same at each session.

The first paper in Vol. VII. is entitled, *A New Method of Exploration, with the Pathology and Treatment pertaining to Certain Lesions of the Female Urethra*, by THOMAS ADDIS EMMET, M.D., of New York. The author first speaks of the difficulties in the differential diagnosis of bladder affections, and the danger of attributing to this organ symptoms of irritation belonging to the rectum or utero-sacral ligaments. Owing to a difficulty of determining the true nature of diseases located within the urethra, he has adopted the plan of opening this canal into the vagina by incision, care being taken to leave the orifice and entrance into the bladder intact. After the introduction of a block-tin sound, he thus describes his method of procedure:—

> "The operation is begun by catching up with a tenaculum the tissues on the vaginal surface, about midway between the mouth of the urethra and the neck of the bladder, and dividing them through the sound. After this entering the canal the incision is to be extended, with a pair of straight-pointed scissors, in the median line backward, towards the neck of the bladder, and forward to within a short distance of the mouth of the urethra. It is necessary to avoid dividing the urethral outlet, as it would then be more difficult to close the opening properly at a future day. And it is still more important that the incision shall stop short of the neck of the bladder without involving it, as the patient would then continue after the operation her control over the escape of urine." . . . "The line along the vaginal surface should be made nearly a third more in length than the one through the urethral mucous membrane, and it is important that the chief difference should be at the end of the line over the neck of the bladder. We thus gain with the bevelled angles a great advantage for examining the urethral tract. Moreover, from the greater length of line being on the vaginal surface, we free the lower angle of the incision at the neck of the bladder, so that if necessary the finger, or a small speculum, can be passed into the vesical cavity with little fear of laceration or loss of control. So long as the vaginal surface is intact, the parts about the neck of the bladder remain bound down and unyielding, from the direct connection of these tissues with the subpubic ligament and pelvic fascia."

If the exploration reveals a condition which can be at once relieved, the wound may be closed at once by silver-wire sutures which are to be passed so as to include the mucous lining of the urethra; if not, the incision may remain open, and be finally closed as in cases of fistulæ and lacerations.

The diseases of the urethra, according to the experience of Dr. Emmet, are: 1. Inflammation of the mucous membrane or urethritis; 2. Pedunculated, vascular, and neuromatoid growths; 3. Prolapse of the mucous and submucous tissues; 4. Fissures at the neck of the bladder; 5. Urethrocele, and 6. Laceration of the urethra from dilatation.

In the discussion of the paper, Dr. Skene, of Brooklyn, deprecated the general use of Dr. Emmet's method of exploration in urethral affections, and characterized the operation as far from simple; disagreeable to the patient; not demanded in some of the conditions enumerated, and as inferior to the use of the endoscope in the detection of ulceration and fissure, the escaping blood obscuring the abnormal appearance. As a means for the removal of morbid growths, and the cure of prolapsus of the urethral mucous lining, he regarded the operation as of great value.

A paper on *The Proper Use of Ergot in Obstetrics*, by JOSEPH TABER JOHNSON, M.D., of Washington, D. C., is taken up with an examination into the effects of ergot in parturition; its failure to excite proper uterine action; its destructive power over fœtal life, and the danger of causing rupture of the uterus. He expresses his own opinion of the drug as follows:—

> "I am free to say, that I think the human race would be better off if ergot should be utterly abolished from the lying-in room. I believe that, as at present employed, it does vastly more harm than good to parturient women and their unborn children. It certainly should never be given to a primipara. It would be safer to give it to no woman in labour; but in careful hands, when its powers are fully known and its dangers appreciated, it might perhaps be administered in the second stage with advantage to overcome uterine inertia, but only then in cases where the soft parts are relaxed, and we are quite certain, both from present appearances and the history of former labours, that the child will be born in a half or three-quarters of an hour. Even then, for the full protection of the child, frequent auscultation should be practised, and, upon its heart becoming slowed or enfeebled, it should at once be extracted with the forceps."
>
> "The use of ergot is contraindicated in retained placenta. It keeps up a state of painful contraction after natural labour, annoys and exhausts the patient needlessly, interferes with the normal discharge of the lochia, and perhaps aids in the causation of septicæmia."

Dr. John P. Reynolds, of Boston, called attention to the hypodermic use of ergotine for the control of post-partum hemorrhage. He thought it good practice to administer ergot after delivery, to lessen the liability to after-pains, by the production of prompt and thorough uterine contraction; it was especially demanded after the long use of anæsthetics. He did not believe that ether, when properly used, predisposed to post-partum hemorrhage.

Dr. Fordyce Barker, of New York, used chloroform in his obstetric practice, and habitually administered ergot after the birth of the child. He thought it diminished the severity of after-pains, and promoted rapid involution; he was in the habit of using it where the woman was feeble, in the first few days of convalescence, in combination with stimulants, iron, and strychnia. In thirty-four years he rarely delivered a woman without anæsthetics, and had never in his own practice had a post-partum hemorrhage; he used chloroform; followed the expulsion by manual pressure, and gave ergot immediately after the expulsion of the placenta.

Dr. J. D. Trask, of Astoria, had had an opposite experience with chloroform, and had decided to abandon its use in cases of normal labour, confident that it favoured post-partum inertia and hemorrhage; he believed that sulphuric ether was less objectionable in this respect.

The Ovarian Cell; its Origin and Characteristics, by Dr. THOMAS M. DRYSDALE, of Philadelphia. In this monograph of thirty-two pages, he defends his position in regard to the diagnostic value of the ovarian cell, claiming that its existence will establish, whether a fluid is ovarian, ascitic, or parovarian. The author has had a large experience in examining fluids taken from the abdominal cavity or viscera, and certainly is able, as a general rule, to state to which of the three orders enumerated a fluid in question belongs. On one occasion Prof. D. Hayes Agnew gave him a fluid for examination, in which he found the characteristic cell. Upon stating what he had found to Dr. Agnew, he was told that the fluid had been taken from the abdominal cavity; upon which he immediately said that the fluid must have escaped from an ovarian cyst, for it was ovarian. In this he was correct, as the ovarian cyst had a small hole in it, as if made with a punch, and the fluid had escaped as claimed. Dr. Drysdale does not claim that there is no similar cell in any other morbid fluid, but that it is not in any other intra-abdominal location except the ovary, after becoming diseased by cystic degeneration. His views have met with much opposition hère and abroad, and others do not appear to have attained to the microscopic expertness claimed by him; but still he holds to the belief, that there is a pathognomonic granular cell indicative of ovarian disease, the only exceptional instance in two thousand cases having been found in the fluid contents of a renal cyst.

Mr. Thornton, of London, Eng., claimed that the so-called cell was only a "nucleus of a rapidly degenerating cell of the cyst membrane." Dr. Drysdale in reply reiterated his opinion, and gave the names of several leading physiologists who had agreed with him.

Treatment of the Pedicle in Ovariotomy is the title of a paper, by Dr. R. STANSBURY SUTTON, of Pittsburgh, Penna. This eleven page monograph is a condensed historical sketch of the operation and the method of treating the pedicle, from the earliest cases down to the time when it was written. The author says in a few words: "It has been tied entire, tied in sections, been twisted off, burnt off, crushed off, cut square off, cut off in flaps, left inside, left outside, and been made to slough off." He shows that the pedicle was at first treated very much as it is now, with the exception, that from 1809 to 1821 the ligature was not cut off, but was brought out through the wound. In 1821 Dr. Nathan Smith inaugurated the method of cutting off the ligature closely and dropping in the pedicle. In 1848, Stilling, of Cassel, introduced the extra-peritoneal method, which is now nearly abandoned except by Mr. Spencer Wells and a few others.

Dr. Sutton describes the operative methods, as he witnessed them, of Prof. Billroth, of Vienna, and Nussbaum, of Munich; Prof. Kuster, and Dr. Martin, of Berlin, Mr. Lawson Tait, Mr. Thornton, Dr. Bantock, Mr. Spencer Wells, Dr. Keith, Dr. Savage, of Birmingham, and Profs. Langenbeck, Shröder, and Esmarch. The monograph is one of much interest because of the personal observations of the author.

In a paper on *Care of the Perineum*, Dr. THEOPHILUS PARVIN, of Indianapolis, now of Philadelphia, describes all the methods known to the profession which have been recommended for the prevention of rupture of the perineum during parturition, and accounts for the frequency of the accident, as due to the formation of the pelvis and soft parts, relative size of the fœtus, use of the forceps, precipitate delivery, employment of ergot, etc. In regard to what he considers the most common of all these, he says: "The great majority of perineal lacerations are caused by precipitate deliveries, force too great, time too short, the expelling power overcoming the resisting part not by stretching but by tearing." This being the case, he recommends a line of practice designed to prevent the too rapid expulsion of the head of the fœtus, and to promote the gradual enlargement of the vulvar outlet. With this view he prefers the lateral decubitus of the patient, cautions her against making expulsive efforts, uses an anæsthetic where she will not control her passion for bearing down, holds back the head by supporting the perineum, and continues this support until the shoulders are delivered. As supporting the perineum has by many been condemned, we give the author's own words: "Supporting the perineum is strengthening the weak part of an elastic ring, and relieving it of excessive strain. The hand should be applied directly, and with no intervention of napkin; support is given only at the close of the second stage, and only during a pain. Supposing the patient to be lying on her left side, and with her hips near the edge of the bed, the practitioner applies his right hand so that the concave palm receives the convexity caused by the bulging perineum, the thumb is on the right, the four fingers upon the labium majus, while the fold between the thumb and index finger corresponds with the anterior margin of the perineum. Great pressure is avoided, lest a thinned part of the perineum may rupture, but moderate resistance made to the driving force, and at the same time the head is gently pressed toward the pubic symphysis."

The operation of incising the perineum to avoid rupture, Dr. Parvin has traced back to 1742, when Ould recommended it in his *Treatise on Midwifery*. He is opposed to the introduction of the fingers into the rectum to aid in the delivery, which is also an old method, as old as the work of Gardien, of Paris, who objected to the method.

We think there are decided objections to supporting the perineum with the bare hand, as recommended. The reviewer prefers to have the orifice of the bowel occluded by a napkin, so as not to receive the contents of the rectum in his hand; and, besides, this is more agreeable to the patient. The napkin need not prevent the operator from feeling what is taking place in the distended parts. As it has been ascertained that a large proportion of lacerations result from the delivery of the shoulders, Dr. Parvin recommends to deliver the pubic shoulder first, and thus diminish the width of the thorax and the risk in delivering the other.

The Relative Value of Hysterectomy and of the Complete Removal of the Uterine Appendages for the Cure of Uterine Fibroids, is the title of a paper by J. KNOWSLEY THORNTON, M.B.C.M., of London. Although the relative mortality in Europe after hysterectomy for uterine fibroids has been less than in this country, the death-rate has been such as to make it desirable to avoid the operation wherever possible, and to substitute for it a less fatal, and, in general, an equally efficient one, *i. e.*, the removal of the ovaries and the enlarged bloodvessels leading to them, in which are also involved the Fallopian tubes. Mr. Thornton gives a table of 221 hysterectomies, performed by ten operators, nine of them Europeans, which resulted in 131 recoveries and 90 deaths. Of this record, Mr. Spencer Wells is credited with 39 cases, Mr. Thornton 25, and Dr. Bantock 21, in all 85, with 35 deaths, or 40.70 per cent. Of these, there were in all 22 cases operated upon for fibro-cysts of the uterus, with 17 recoveries and 5 deaths, a loss of 22.72 per cent. In contrast with these results, he gives the following as the diminished mortality under the substitute of Battey: "Tait, 38 cases, 33 recoveries, 5 deaths; Savage, 14 cases, 14 recoveries, no deaths; Thornton, 8 cases, 8 recoveries, no deaths; total, 60 cases, 55 recoveries, 5 deaths; mortality 8.16 per cent."

In the discussion of the paper, Dr. Goodell stated his preference for enucleation, which he had performed successfully a number of times, to the removal of the uterus. Of four oöphorectomies for fibroid tumours, two had proved fatal; all having been performed in a general hospital. He preferred this operation to hysterectomy, which had been so fatal in this country. In his experience, also, exploratory incisions in cases of large fibroid and fibro-cystic tumours had proved dangerous to life.

Dr. T. G. Thomas had removed the uterus for solid or fibro-cystic tumours in 13 cases, with 7 recoveries. He gave it as his opinion, that one-fourth of all Anglo-Saxon women (*i. e.*, above 40 years of age) have fibroid tumours of the uterus. Klob claimed as high as 40 per cent. from his *post-mortem* investigations. Among the coloured women of this country the rate is believed to be fully this. Dr. Thomas also expressed a decided preference for enucleation over hysterectomy in the cases where it is practicable. He recommended the use of the curette for controlling the uterine hemorrhage dependent upon the existence of large tumours, and also called attention to the fact, that in some such cases the real cause of hemorrhage existed in a removable growth within the uterine cavity, and not in the more noticeable fibroid.

Electricity in Extra-Uterine Pregnancy. HENRY J. GARRIGUES, M.D., of New York, was led to prepare this valuable paper for two reasons: 1. He noticed that, notwithstanding the attention that had been drawn to this subject in the United States, and the successful treatment of the cases, quite a number of writers in Europe appeared to be still in ignorance of the value of electricity as a fœticidal expedient, and of the safety with which it could be used in the early period of extra-uterine pregnancies. 2. He had additional evidence of its value in the fact that he had operated with success in his own practice.

Dr. Garrigues gives the records of eleven cases including his own, in which electricity has been used for the destruction of the fœtus in tubal pregnancies, as follows, which, for brevity, we have here presented under a tabular arrangement, condensed from his abstract reports:—

No.	Name of operator.	Locality.	Year.	Age of woman.	Number of pregnancy.	Estimated duration of pregnancy.	No. of treatments.	Result to woman.	Special notice.
1	Dr. Bachetti	Pisa, Italy	1853	29	4-para	In 3d mo.	Once	Recov.	
2	Dr. Braxton Hicks	London	1866	35	3-para	3¼ mos.	Twice	Died	Cyst punctured per vaginam.
3	Dr. Joshua G. Allen	Philadelphia	1869	?	Pluripara	In 4th mo.	Several	Recov.	
4	Drs. Loving and Landis	Columbus, O.	1872	?	Pluripara	3 months	Eight	"	
5	Dr. McBurney	New York	1878	21	1-para	2 mos. 3½ weeks	Twice	"	
6	Dr. J. C. Reeve.	Dayton, O.	1879	25	2-para	3 months	8 or 9	"	
7	Dr. L. C. Billington	New York	1880	34	2-para	End of 3d month.	4 times	"	
8	Dr. W. T. Lusk	"	1880	28	2-para	2 months	Several	"	
9	Dr. Bache Emmet	"	1881	28	1-para	3½ "	Three	"	
10	Dr. Henry G. Landis	Columbus, O.	1881	?	Pluripara	3 "	Six	"	Same as No. 4.
11	Dr. Henry J. Garrigues	New York	1882	19	1-para	2 "	Ten	"	

Dr. Garrigues says of his method: "I used a French one-cell apparatus, composed of two carbon plates, and one zinc plate, immersed in Bunsen's battery fluid (potass. bichrom. ℥ij; acid. sulphuric. concentr. f℥iss; aquæ fluv. f℥xj). The positive electrode, made of a large carbon plate, covered with cloth, was applied on the abdomen, over the tumour. The negative electrode, consisting of one isolated brass stem, with knob, was introduced into the vagina, and pressed up against the lower part of the tumour. The current was gradually increased to the limit of her endurance, but never enough to cause real pain." Two days later, the pulsation of the tumour, previously felt in the vagina, had disappeared, and the tumour was less in size. The applications were made, of about ten minutes' duration each, and were continued, almost daily, for two weeks. In sixteen days, the tumour had gone down to the size of an English walnut.

T. GAILLARD THOMAS, M.D., of New York, presents *The History of Twenty-one Cases of Extra-Uterine Pregnancy coming under the personal observation of the Writer.* Of these cases three occurred in Dr.

Thomas's own practice, and eighteen were seen in consultation. Nos. 16, 17, 18, and 19 are the same cases as 5, 7, 8, and 9 in the table prepared from the record of Dr. Garrigues. Nos. 15 and 21 were also treated successfully by electricity. There were thirteen recoveries and eight deaths in the cases. Rupture of the sac occurred in five cases, with four deaths. Laparotomy was performed in three cases; all recovered. In two the cysts were tapped; both died. One cyst was incised per vaginam by the thermo-cautery knife, with recovery, and one was evacuated per rectum, but the patient died. In two, spontaneous evacuation by the rectum occurred, and they recovered.

In the discussion Dr. Wilson, of Baltimore, reported two cases, with one recovery; Dr. Howard three cases, all fatal; and Dr. Goodell, of Philadelphia, thirteen cases, with three recoveries. A very large number of cases might readily be added to these.

The Influence of the Constant Use of High-heeled French Shoes upon the Health and Form of the Female, and upon the Relation of the Female Organs. After some historical remarks upon the shoe, commencing with its earliest form, **Samuel C. Busey**, M.D., of Washington, D. C., in a paper of eighteen pages, endeavours to prove that the wearing of the French high-heeled shoe by American women alters the direction of their ankle, knee, and hip-joints, the obliquity of their pelves, and the line of their spinal columns; and tends to produce muscular fatigue, to interfere with taking proper exercise, and to induce displacement and disease in the pelvic viscera.

Drs. Barker and Thomas, of New York, whilst commending the theories of Dr. Busey, were compelled from a large experience with the cases of fashionable women to admit, that what might be expected to follow the wearing of high-heeled shoes was not observable in the walk, carriage, and contour of the wearers. They were inclined to attribute the diseases of the pelvic viscera to innate or other causes. Dr. Busey had taken a series of photographs to illustrate the effect of the shoe upon the line of the body and lower extremities, but these were not used in the publication of his paper because of some errors in their preparation. From our own observations we are inclined to believe that the chief injuries produced by the high heel are located in the ankle-joint, tarsal bones, metatarso-phalangeal articulation of the great toe, and the tendons, which are compelled to move the foot in an unnatural position.

Mechanical Therapeutics of Versions and Flexions of the Uterus, by **Ely Van de Warker**, M.D., of Syracuse, N. Y. This article, covering with its illustrations some sixty pages, in which are presented the numerous forms of pessaries invented by gynecologists, cannot be given in abstract, but must be examined to be understood and appreciated. A glance at its armamentarium is sufficient to demonstrate that with all the contrivances in use, there is still a great difficulty in overcoming abnormal forms and positions of the uterus by mechanical means; the location of the organ, its relations with the rectum, bladder, and abdominal viscera, and its imperfect support, making any appliance more or less imperfect in its action as a rectifier of form or position.

Dr. Van de Warker classifies the version and flexion pessaries in use under three groups and eleven classes. The three groups are: 1. Pessaries, with external support. 2. Pessaries acting within the vagina. 3. Intra-uterine stems. The paper is one of great labour and research, and its illustrations are a museum of pessaries and stem supports.

J. Collins Warren, M.D., of Boston, contributes a paper entitled *A New Method of Operation for the Relief of Rupture of the Perineum through the Sphincter and Rectum.* The object of the plan of operation devised by Dr. Warren is to shield the rectal portion of the rent after its closure, so that no fecal matter can come in contact with the cicatrizing edges. This is accomplished by preserving the thin portion of cicatricial tissue, which is dissected off in the denudation of the lips of the rent, in an entire state, and turning it down and into the rectum, so that what is vaginal surface shall become a portion of the lining of the bowel thrown up in a fold over the stitched wound. When the denuded surfaces are brought into contact and secured by wire sutures, the turned-down flap is to be folded as a ridge in the rectum, and the projecting part cut off, but not too short, and the raw edges stitched together. As the wound heals the flap retracts, and finally leaves little or no recognizable ridge in the rectum.

Dr. Warren keeps the bowels inactive for a number of days after operating, and to escape having caseous concretions in the rectum, and the consequent difficulty of defecation, avoids the use of milk as a diet, and substitues for it beef-tea and other liquid dietetic preparations.

Dr. **Matthew D. Mann**, of Buffalo, N. Y., in a paper of very great interest, entitled *Surgical Operations on the Pelvic Organs of Pregnant Women*, presented a number of facts based upon the experience of a large number of American and European writers and gynecologists. The whole range of the operations in question has been thoroughly examined, and their effects as factors in the production of abortion noted. It was at one time thought hazardous even to pull a tooth for a pregnant woman, and we have no doubt that this opinion originated in an actual case; but we have become wiser, and do not hesitate to extract teeth; and have but little fear from the effects of much more serious operations. The conclusions of the author, which are based upon the facts elicited, are as follows:—

"1. Pregnancy is not so decidedly a bar to operations on the pelvic organs as is generally supposed. The results, however, vary with the operation and the organ operated upon."

"2. Union of denuded surfaces is the rule, and the cicatricial tissue formed during the earlier months of pregnancy is strong enough to resist the shock of labour at term."

"3. *Operations on the vulva* involve very little danger either to mother or child."

"4. *Operations on the vagina* are likely to cause severe hemorrhages, but are not otherwise dangerous."

"5. Venereal warts and vegetations of large size and non-syphilitic are best treated by removal, whether they occur in the vagina or are confined to the vulva."

"6. Applications of nitrate of silver and astringents of this class may be made with safety to the vagina and cervix. Diffusible poisons, like carbolic acid and iodine, should not be used pure or in strong solutions for such applications."

"7. *Operations upon the bladder and urethra* are not dangerous, or likely to be followed by abortion."

"8. *Operations on the rectum* involving the sphincter ani, even if slight in their character, are dangerous."

"9. *The operation for vesico-vaginal fistula* should not be undertaken during pregnancy, as the dangers of hemorrhage and abortion are considerable."

"10. *Plastic operations on the cervix and perineum* may, if necessary, be undertaken in the earlier months of pregnancy with a fair prospect of success, and with a good chance that the results may not be impaired by labour."

"11. Small polypi of the cervix may best be treated by torsion or strong astringents. If cut, there is some danger of abortion following."

"12. Large polypi may, if causing hemorrhage, be removed at once, with a fair chance of good results. If not doing any harm, their removal is best left until near the close of pregnancy."

"13. Cancer of the cervix discovered during pregnancy should, if possible, be removed at once."

These opinions are based upon the results of ninety operations, causing twenty abortions and four deaths. Thirteen of the twenty abortions were produced by thirty-four operations on the rectum, anus, perineum, and cervix, with two of the deaths.

It must be borne in mind, that the uterus is much more readily excited to expel its contained ovum in some women than in others, a mere trifle being enough in some cases to excite an abortion. The reviewer had a patient of fine physique whose disgust for caterpillars was such, that she miscarried twice through their getting upon her. Once, the unexpected fall of one from a tree upon her bare head caused an immediate uterine action resulting in her having a miscarriage within a few hours.

In a paper entitled, *Hyperemia of the Vesico-Urethral Membrane*, Dr. W. H. Baker, of Boston, describes the diseased condition he proposes to consider thus:—

> "The cases of vesico-urethral hyperemia to which I would limit the considerations of this paper, are those where the mucous membrane of the bladder and the urethra being perfectly healthy, except at the point of their junction, there exist at this last-mentioned site a few tortuous bloodvessels running over an otherwise healthy membrane. These bloodvessels are evidently veins, as the most careful examination fails to discover in them the least pulsation. It seems almost incredible that so slight a deviation from a normal condition should create so great a disturbance to the nervous system, and cause so much local pain as I have seen present."

After determining the existence of this diseased condition by the use of Skene's endoscope, and failing to produce a cure by local applications, Dr. Baker opens the bladder as for the treatment of cystitis, making a vesico-vaginal fistula, so that no urine shall pass through the urethra until it is restored to its normal condition. He next directs the patient to inject the bladder with water at 105° to 110° from a fountain syringe to which is fitted a small straight nozzle of metal or hard rubber, a quarter of an inch shorter than the urethra. This is used freely every day for two or three weeks, when a little alum, tannin, or zinc, is added to the water. Four to six months of this treatment are required to cure the hyperemia in some cases, the fistula being kept open by the daily passage of the index finger of the patient. When the disease is removed the fistula is to be closed by an operation. During the period of leaking, the patient is to wear either an external urinal, or one fitted in the vagina to the fistula, so as to receive the dribbling urine. Five clinical records showing management and cures are given. R. P. H.